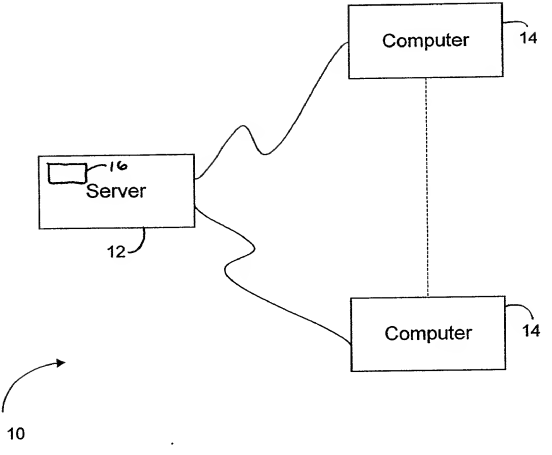

FIG. 1

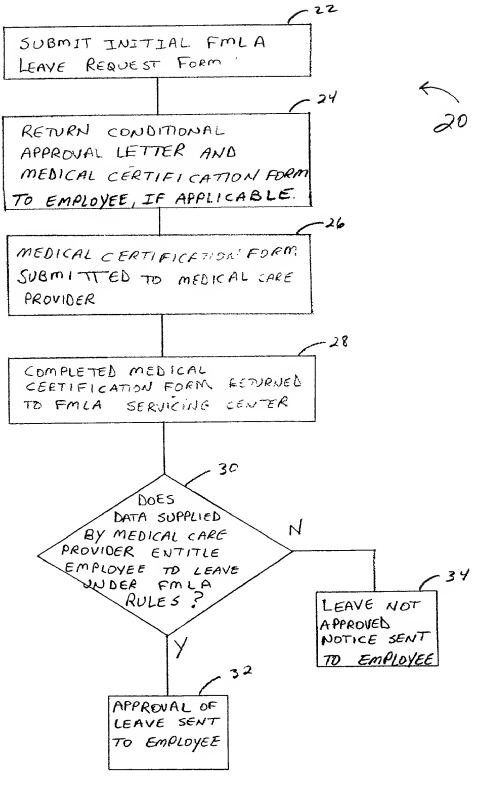
22
SUBMIT INITIAL FMLA LEAVE REQUEST FORM
24
RETURN CONDITIONAL APPROVAL LETTER AND MEDICAL CERTIFICATION FORM TO EMPLOYEE, IF APPLICABLE.
20
26
MEDICAL CERTIFICATION FORM SUBMITTED TO MEDICAL CARE PROVIDER
28
COMPLETED MEDICAL CERTIFICATION FORM RETURNED TO FMLA SERVICING CENTER
30
DOES DATA SUPPLIED BY MEDICAL CARE PROVIDER ENTITLE EMPLOYEE TO LEAVE UNDER FMLA RULES ?
N
34
LEAVE NOT APPROVED NOTICE SENT TO EMPLOYEE
Y
32
APPROVAL OF LEAVE SENT TO EMPLOYEE

FIG. 2

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1 2 3

Initial FMLA Leave Request Form

Any incomplete information will delay the processing of this request.

52 **If you have any questions, please call the FMLA Center toll free at 877-555-FMLA/(877)-555-3652.**

1 Form submitted by: _____ (86) *if different from employee* _____ (88) *GE Capital Business* Date: _____ (66)

Employee Name: John Smith (58) SS No.: 123-45-6789 (64)

Home address: _____ (60) (Street) _____ (City) _____ (State) _____ (ZIP)

Home phone: _____ (62) MGR: _____ (70) HR Rep.: _____ (74)

Date of Hire: _____ (68) (mm/dd/yy) MGR phone: _____ (72) HR Rep. phone: _____ (76)

Work Location: _____ (78) (City/State) Current Work Schedule: _____ (82) (Days/Hours per week)

Work phone: _____ (80) 84 ☐ **Check this box if you are applying for disability benefits.** *(note: you must call the disability center to apply for disability benefits)*

2 (54) Reason for Leave

Please check (✓) the reason for the leave you are requesting.

HOSPITAL

☐ Inpatient hospital stay, recovery from stay or treatment related to stay. (90)

PREGNANCY

☐ Incapacity due to pregnancy and prenatal care (before the child is born). (92)
Expected delivery date: _____
or (104)

NEW CHILD

☐ Time to care for a newborn child or a newly placed adopted or foster care child (for moms ***and*** dads). (94)

PERSONAL MEDICAL CONDITION

☐ Too sick to work for more than three consecutive days (including non-work days), ***and*** saw a health care provider twice; (96)
or

☐ Too sick to work for more than three consecutive days (including non-work days), ***and*** saw a health care provider once ***and*** given a continuing regimen of treatment (e.g., therapy, medication); (98)
or

☐ Incapacitated by or out to receive treatment for a serious chronic or permanent health condition (e.g., asthma, diabetes, cancer). (100)

FAMILY

☐ To take care of/provide support for a sick eligible family member who falls into one of the categories above (except care of a new child). (102)

_____ (106)
(Name of family member & relationship to you)

3 (56) Type of Leave

Please check (✓) the type of leave you are requesting.

☐ (108) **Full, Continuous Leave**

Requested time period:

Begin date: _____ (110) (mm/dd/yy) to _____ (112) (mm/dd/yy) end date

☐ (114) **Reduced Schedule**

Requested reduced work schedule:

_____ (116) hrs./day

_____ (118) hrs./week

_____ (120) days/week

Time period for which you are requesting the reduced schedule:

Begin date: _____ (122) (mm/dd/yy) to _____ (124) (mm/dd/yy) end date

☐ (126) **Intermittent Leave** (i.e., occasional, episodic)

If the medical condition is occasional or episodic, we require a specific time period for coverage under the FMLA (up to 1 year maximum.)

Begin date: _____ (128) (mm/dd/yy) to _____ (130) (mm/dd/yy) end date

FIG. 3

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Medical Certification for FMLA - Employee

Take this form to your medical provider for certification.

For questions regarding this form call 877-555-FMLA/877-555-3652. Return to the FMLA Center by _____

148 **Name:** John Smith **SS No.:** 123-45-6789 150

1 Reason for Leave — Medical Provider must check (✓) any and all that apply.

142 **PREGNANCY** — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated*** due to pregnancy.
- ☐ Receiving prenatal care. — Expected delivery date: _____

MEDICAL CONDITION — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated*** for **more than 3 consecutive days** and received **treatment at least 2 times** for this condition.
- ☐ **Incapacitated*** for **more than 3 consecutive days** and received **treatment** for this condition and prescribed a regimen of continuing treatment (i.e. therapy, Rx).
- ☐ **Incapacitated*** by or **out of work** to receive treatment for a **chronic** serious health condition which 1) requires **periodic visits/treatment** and 2) continues over extended period of time and 3) causes **episodic or continuing incapacity***.
- ☐ **Incapacitated*** by a **permanent/long-term condition** for which patient is undergoing continuing treatment (i.e. Alzheimer's, severe stroke).
- ☐ **Out of work** to undergo **examination/testing** for a condition that would likely fall into one of the categories listed above or require inpatient stay.

* **Unable to work or perform regular daily activities.**

HOSPITAL STAY — *I certify that the above patient is/has been/will be:*

- ☐ **Inpatient** in a **hospital, hospice, or residential** medical care **facility.**
- ☐ Out of work to receive **treatment** for a condition connected to previous inpatient stay.
- ☐ **Recovering** from inpatient stay and incapacitated (unable to work or perform regular daily activities).

2 Dates/Time of Leave — Medical provider must indicate dates and times of leave

144 **Continuous Leave:** (If Requested) — *I certify that the above patient has a medical need for leave as described.*

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Reduced Hours: (If Requested) — *I certify that the above patient has a medical need for leave as described.*

Requested reduced hours schedule _____ hrs./day _____ hrs./week _____ days/week

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Intermittent (i.e., occasional, episodic) Leave: (If Requested) — *I certify that the above patient has a medical need for leave as described.*

Requested intermittent schedule _____ hrs./day _____ hrs./week _____ days/week

146 *Indicate approximate duration of medical condition* — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

3 Signature Stamp — Medical provider must sign and return form to the FMLA Center

Medical Provider Signature: 152 ***Phone:*** 154 ***Fax:*** 156

Print Name: 158 ***Type of Practice:*** 160 (field of specialty, if any)

Address: 162 (city) (state) (zip)

FIG. 4

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Medical Certification for FMLA - Family Member

Take this form to your family member's medical provider for certification.

For questions regarding this form call 877-CSC-FMLA/877-272-3652. Return to the FMLA Center by _____ 174

Patient Name: John Smith 172 ***Relationship to Employee:*** SPOUSE

Employee Name Janice Doe 148 ***SS No.:*** 123-45-6781 150

1 Reason for Leave — Medical Provider must check (✓) any and all that apply.

142

PREGNANCY — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated*** due to pregnancy.
- ☐ Receiving prenatal care. — Expected delivery date: _____

MEDICAL CONDITION — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated* for more than 3 consecutive days** and received **treatment at least 2 times** for this condition.
- ☐ **Incapacitated* for more than 3 consecutive days** and received **treatment** for this condition and prescribed a regimen of continuing treatment (i.e. therapy, Rx).
- ☐ **Incapacitated*** by or **out of work** to receive treatment for a **chronic** serious health condition which 1) requires **periodic visits/treatment** and 2) continues over extended period of time and 3) causes **episodic** or **continuing incapacity***.
- ☐ **Incapacitated*** by a **permanent/long-term condition** for which patient is undergoing continuing treatment (i.e. Alzheimer's, severe stroke).
- ☐ **Out of work** to undergo **examination/testing** for a condition that would likely fall into one of the categories listed above or require inpatient stay.

*** Unable to work or perform regular daily activities.**

HOSPITAL STAY — *I certify that the above patient is/has been/will be:*

- ☐ **Inpatient** in a **hospital, hospice, or residential** medical care **facility**.
- ☐ Out of work to receive **treatment** for a condition connected to previous inpatient stay.
- ☐ **Recovering** from inpatient stay and incapacitated (unable to work or perform regular daily activities).

2 Dates/Time of Leave — Medical provider must indicate dates and times of leave for the employee

144

Continuous Leave: (If Requested) — *I certify that the above employee is needed to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period:*

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Reduced Hours: (If Requested) — *I certify that the above employee needs reduced work hours to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period:*

Requested reduced hours schedule _____ hrs./day _____ hrs./week _____ days/week

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Intermittent (i.e., occasional, episodic) Leave: (If Requested) — *I certify that the above employee needs intermittent leave to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 of incapable of self-care), or parent for the following time period:*

Requested intermittent schedule _____ hrs./day _____ hrs./week _____ days/week

Indicate approximate duration of medical condition — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

3 Signature Stamp — Medical provider must sign and return form to the FMLA Center

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Medical Provider Signature: _____ 152 ***Phone:*** _____ 154 ***Fax:*** _____ 156

Print Name: _____ 158 ***Type of Practice:*** _____ 160 (field of specialty, if any)

Address: _____ 162 (city) (state) (zip)

FIG. 5